

Application for License to
Operate a Long-term Care Facility

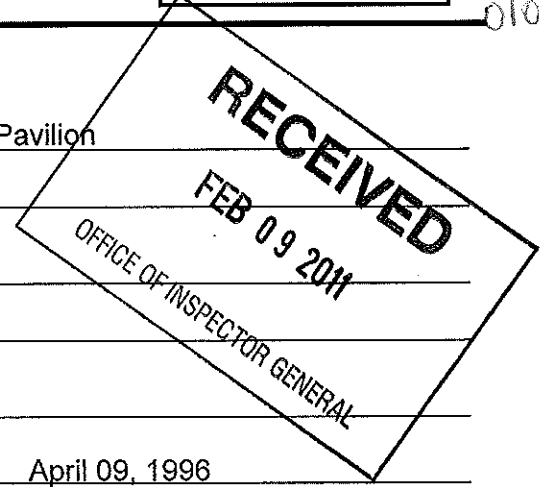
For Office Use Only
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Amount \$1650

emailed validation letter
2/25/11

Ch#
010632

I. IDENTIFICATION

Name Cal Turner Extended Care Pavilion
Address 456 Burnley Road
City/County/Zip Scottsville/Allen/42164
Telephone number 270-622-2800
Administrator Eric A. Hagan
Date facility operation began at current address April 09, 1996
Date facility began operation under current owner January 01, 1995



II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	<u> </u>	<u> </u>
Nursing Home	<u> </u>	<u> </u>
Nursing Facility	<u>110</u>	<u> </u>
Intermediate Care	<u> </u>	<u> </u>
ICF/MR	<u> </u>	<u> </u>
Personal Care	<u> </u>	<u> </u>

II. CONTROL (check one in each column)

State	Profit	Individual
County	Nonprofit- X	Partnership
City		Corporation- X
Private- X		

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

Bowling Green Warren County Community Hospital Corp. d/b/a Cal Turner Extended

Care Pavilion

250 Park Street, Bowling Green, KY 42102

(OVER)

If facility owned or leased by a corporation, complete the following:

Name of corporation Commonwealth Health Corporation
Address of corporation 800 Park Street Bowling Green, KY 42102
President or Chairman Connie Smith
Vice President _____
Secretary _____
Treasurer _____

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

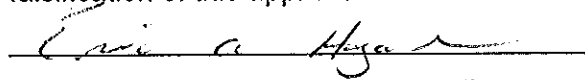
If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company
<u>Commonwealth Health Corporation</u>	_____
<u>800 Park Street</u>	_____
<u>Bowling Green, KY 42102</u>	_____

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.


<u></u>	<u>Administrator</u>	<u>02/07/11</u>
Signature of authorized representative	Title	Date

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621



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